ANGER MANAGEMENT

BEHAVIORAL DEFINITIONS

1. History of explosive aggressive outbursts out of proportion to any precipitating stressors, leading to assaultive acts or destruction of property.
2. Overreactive hostility to insignificant irritants.
3. Swift and harsh judgment statements made to or about others.
4. Body language of tense muscles (e.g., clenched fist or jaw), glaring looks, or refusal to make eye contact.
5. Use of passive-aggressive patterns (e.g., social withdrawal, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, nonparticipation in meeting expected behavioral norms) due to anger.
6. Consistent pattern of challenging or disrespectful attitudes toward authority figures.
7. Use of abusive language.

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LONG-TERM GOALS

1. Decrease overall intensity and frequency of angry feelings, and increase ability to recognize and appropriately express angry feelings as they occur.

2. Develop an awareness of current angry behaviors, clarifying origins of and alternatives to aggressive anger.
3. Come to an awareness and acceptance of angry feelings while developing better control and more serenity.
4. Become capable of handling angry feelings in constructive ways that enhance daily functioning.

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SHORT-TERM OBJECTIVES

1. Verbally acknowledge frequently feeling angry. (1)
2. Identify targets of and causes for anger. (2, 3, 4)
3. Verbalize increased awareness of anger expression patterns. (5, 6)

THERAPEUTIC INTERVENTIONS

1. Assist the client in coming to the realization that he/she is angry, by reviewing triggers and frequency of angry outbursts.
2. Assign the client to read the book *Of Course You're Angry* (Rosellini and Worden) or *The Angry Book* (Rubin).
3. Ask the client to keep a daily journal in which he/she documents persons, situations, and so on that cause anger, irritation, or disappointment.
4. Assign and process a list of all the client's targets of and causes for anger.
5. Confront/reflect the client's angry behaviors that occur within sessions.
6. Refer the client to an anger management class or group.

4. Verbalize how people influential in your upbringing have modeled anger expressions. (7)

5. Identify pain and hurt of past or current life that fuels anger. (8, 9)

6. Verbalize feelings of anger in a controlled, assertive way. (10, 11, 12)

7. Decrease the number and duration of angry outbursts. (11, 13)

7. Assist the client in identifying ways that key life figures (e.g., father, mother, teachers) have expressed angry feelings and how these experiences have positively or negatively influenced the way he/she handles anger.

8. Assign the client to list the experiences of life that have hurt him/her and led to anger.

9. Empathize with and clarify the client's feelings of hurt and anger tied to traumas of the past.

10. Assign the client to attend assertiveness training classes.

11. Process the client's angry feelings or angry outbursts that have recently occurred and review alternative behaviors available.

12. Using role-playing techniques, assist the client in developing non-self-defeating ways (e.g., assertive use of "I messages") of handling angry feelings.

11. Process the client's angry feelings or angry outbursts that have recently occurred and review alternative behaviors available.

13. Assign a specific exercise from the *Anger Work Out Book* (Weisinger) or similar workbook and process the exercise with the client.

8. Utilize relaxation techniques to cope with angry feelings. (14)

9. Verbalize increased awareness of how past ways of handling angry feelings have had a negative impact. (15, 16)

10. Decrease verbal and physical manifestations of anger, aggression, or violence while increasing awareness and acceptance of feelings. (17, 18)

11. Verbalize increased awareness of and ability to react to hot buttons or anger triggers in a nonaggressive manner. (19)

12. Write an angry letter to target of anger and process this letter with the therapist. (20, 21)

14. Teach the client relaxation techniques (e.g., deep breathing, positive imagery, deep muscle relaxation) to help him/her to respond appropriately to angry feelings when they occur.

15. Ask the client to list ways anger has negatively impacted his/her daily life; process this list.

16. Expand the client's awareness of the negative affects that anger has on his/her body.

17. Use the empty chair technique to coach the client in expressing his/her angry feelings in a constructive, non-self-defeating manner.

18. Train the client in Rational Emotive Therapy (RET) techniques for coping with feelings of anger, frustration, and rage.

19. Assist the client in developing the ability to recognize his/her hot buttons/triggers that lead to angry explosions.

20. Ask the client to write an angry letter to parents, spouse, or whomever, focusing on the reasons for his/her anger toward that person; process this letter in session.

21. While in session, encourage the client to express and release feelings of anger or

13. Verbalize recognition of how holding on to angry feelings freezes you and hands control over to others, and cite the advantages of forgiveness. (22, 23)
14. Write a letter of forgiveness to the perpetrator of past or present pain and process this letter with the therapist. (24)

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rage, violent fantasies, or plots for revenge.

22. Discuss with the client forgiveness of the perpetrators of pain as a process of letting go of his/her anger.
23. Assign the client to read *Forgive and Forget* (Smedes).
24. Ask the client to write a forgiving letter to the target of anger as a step toward letting go of anger; process this letter in session.

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.43	Intermittent Explosive Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.8	Conduct Disorder
	310.1	Personality Change Due to (Axis III Disorder)
	309.81	Posttraumatic Stress Disorder
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.0	Paranoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

ANTISOCIAL BEHAVIOR

BEHAVIORAL DEFINITIONS

1. An adolescent history of consistent rule-breaking, lying, stealing, physical aggression, disrespect for others and their property, and/or substance abuse resulting in frequent confrontation with authority.
2. Failure to conform with social norms with respect to the law, as shown by repeatedly performed antisocial acts (e.g., destroying property, stealing, or pursuing an illegal job) for which he/she may or may not have been arrested.
3. Pattern of interacting in a confrontive, aggressive, and/or argumentative way with authority figures.
4. Little or no remorse for causing pain to others.
5. Consistent pattern of blaming others for what happens to him/her.
6. Little regard for truth as reflected in a pattern of consistently lying to and/or conning others.
7. Frequent initiation of verbal or physical fighting.
8. History of reckless behaviors that reflect a lack of regard for self or others and show a high need for excitement, fun, and living on the edge.
9. Pattern of sexual promiscuity; has never been totally monogamous in any relationship for a year and does not take responsibility for children resulting from relationships.
10. Pattern of impulsive behaviors, such as moving often, traveling with no goal, or quitting a job without having secured another one.
11. Inability to sustain behavior that would maintain consistent employment.
12. Failure to function as a consistently concerned and responsible parent.

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LONG-TERM GOALS

1. Accept responsibility for own behavior and keep behavior within the acceptable limits of the rules of society.
2. Develop and demonstrate a healthy sense of respect for social norms, the rights of others, and the need for honesty.
3. Improve method of relating to the world, especially authority figures; be more realistic, less defiant, and more socially sensitive.
4. Come to an understanding and acceptance of the need for conforming to prevailing social limits and boundaries on behavior.
5. Maintain consistent employment and demonstrate financial and emotional responsibility for children.

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SHORT-TERM OBJECTIVES

1. Admit to illegal and/or unethical behavior that has trampled on the law and/or the rights and feelings of others. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Explore the history of the client's pattern of illegal and/or unethical behavior and confront his/her attempts at minimization, denial, or projection of blame.
2. Review the consequences for the client and others of his/her antisocial behavior.

2. Verbalize an understanding of the benefits for self and others of living within the laws and rules of society. (3, 4)	3. Teach the client that the basis for all relationships is trust that the other person will treat one with respect and kindness. 4. Teach the client the need for lawfulness as the basis for trust that forestalls anarchy in society as a whole.
3. Make a commitment to live within the rules and laws of society. (5, 6)	5. Solicit a commitment from the client to conform to a pro-social, law-abiding lifestyle. 6. Emphasize the reality of negative consequences for the client if he/she continues to practice lawlessness.
4. List relationships that have been broken because of disrespect, disloyalty, aggression, or dishonesty. (7, 8)	7. Review relationships that have been lost due to the client's antisocial attitudes and practices (e.g., disloyalty, dishonesty, aggression). 8. Confront the client's lack of sensitivity to the needs and feelings of others.
5. Acknowledge a pattern of selfcenteredness in virtually all relationships. (8, 9)	8. Confront the client's lack of sensitivity to the needs and feelings of others. 9. Point out the self-focused, me-first, look-out-for-number-one attitude that is reflected in the client's antisocial behavior.
6. Make a commitment to be honest and reliable. (10, 11, 12)	10. Teach the client the value for self of honesty and reliability in all relationships, since he/she benefits from social approval as well as increased trust and respect.

11. Teach the client the positive effect that honesty and reliability have for others, since they are not disappointed or hurt by lies and broken promises.
12. Ask the client to make a commitment to be honest and reliable.

7. Verbalize an understanding of the benefits to self and others of being empathetic and sensitive to the needs of others. (3, 13, 14)

3. Teach the client that the basis for all relationships is trust that the other person will treat one with respect and kindness.
13. Attempt to sensitize the client to his/her lack of empathy for others, by revisiting the consequences of his/her behavior on others. Use role-reversal techniques.
14. Confront the client when he/she is rude or not being respectful of others and their boundaries.

8. List three actions that will be performed that will be acts of kindness and thoughtfulness toward others. (15)

15. Assist the client in listing three actions that he/she will perform as acts of service or kindness for others.

9. Indicate the steps that will be taken to make amends or restitution for hurt caused to others. (16, 17, 18)

16. Assist the client in identifying those who have been hurt by his/her antisocial behavior.
17. Teach the client the value of apologizing for hurt caused as a means of accepting responsibility for behavior and of developing sensitivity to the feelings of others.

18. Encourage the client's commitment to specific steps that will be taken to apologize and make restitution to those who have suffered from his/her hurtful behaviors.

10. Verbally demonstrate an understanding of the rules and duties related to employment. (19)

19. Review the rules and expectations that must govern the client's behavior in the work environment.

11. Attend work reliably and treat supervisors and coworkers with respect. (20, 21)

20. Monitor the client's attendance at work and reinforce reliability as well as respect for authority.

21. Ask the client to make a list of behaviors and attitudes that must be modified in order to decrease his/her conflict with authorities; process the list.

12. Verbalize the obligations of parenthood that have been ignored. (22, 23)

22. Confront the client's avoidance of responsibilities toward his/her children.

23. Assist the client in listing the behaviors that are required to be a responsible, nurturing, consistently reliable parent.

13. State a plan to meet responsibilities of parenthood. (24)

24. Develop a plan with the client that will begin to implement the behaviors of a responsible parent.

14. Increase statements of accepting responsibility for own behavior. (25, 26, 27)

25. Confront the client when he/she makes blaming statements or fails to take responsibility for own actions, thoughts, or feelings.

26. Explore the client's reasons for blaming others for

	his/her own actions (e.g., history of physically abusive punishment, parental modeling, fear of rejection, shame, low self-esteem, avoidance of facing consequences).
	27. Give verbal positive feedback to the client when he/she takes responsibility for his/her own behavior.
15. Verbalize an understanding of how childhood experiences of pain have led to an imitative pattern of self-focused protection and aggression toward others. (28, 29)	28. Explore the client's history of abuse, neglect, or abandonment in childhood; explain how the cycle of abuse or neglect is repeating itself in the client's behavior.
	29. Point out that the client's pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt to protect self from pain.
16. Verbalize a desire to forgive perpetrators of childhood abuse. (30)	30. Teach the client the value of forgiving the perpetrators of hurt versus holding on to hurt and rage and using the hurt as an excuse to continue antisocial practices.
17. Practice trusting a significant other with disclosure of personal feelings. (31, 32, 33)	31. Explore the client's fears associated with placing trust in others.
	32. Identify some personal thoughts and feelings that the client could share with a significant other as a means of beginning to demonstrate trust in someone.

33. Process the experience of the client making self vulnerable by self-disclosing to someone.

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DIAGNOSTIC SUGGESTIONS

Axis I:	303.90	Alcohol Dependence
	304.20	Cocaine Dependence
	304.89	Polysubstance Dependence
	309.3	Adjustment Disorder With Disturbance of Conduct
	312.8	Conduct Disorder
	312.34	Intermittent Explosive Disorder
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.81	Narcissistic Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

ANXIETY

BEHAVIORAL DEFINITIONS

1. Excessive and persistent daily worry about several life circumstances that has no factual or logical basis.
2. Motor tension such as restlessness, tiredness, shakiness, or muscle tension.
3. Autonomic hyperactivity such as palpitations, shortness of breath, dry mouth, trouble swallowing, nausea, or diarrhea.
4. Hypervigilance such as feeling constantly on edge, experiencing concentration difficulties, having trouble falling or staying asleep, and exhibiting a general state of irritability.

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LONG-TERM GOALS

1. Reduce overall level, frequency, and intensity of the anxiety so that daily functioning is not impaired.
2. Stabilize anxiety level while increasing ability to function on a daily basis.
3. Resolve the core conflict that is the source of anxiety.
4. Enhance ability to handle effectively the full variety of life's anxieties.

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SHORT-TERM OBJECTIVES

1. Tell the story of the anxiety complete with attempts to resolve it and the suggestions others have given. (1, 2)
2. Identify the major life conflicts from the past and present that form the basis for present anxiety. (3, 4, 5)
3. Complete anxiety homework exercises that identify cognitive distortions that generate anxious feelings. (6)

THERAPEUTIC INTERVENTIONS

1. Build a level of trust with the client and create a supportive environment that will facilitate a description of his/her fears.
2. Probe with questions (see *Anxiety Disorders and Phobias* by Beck and Emery) that require the client to produce evidence of the anxiety and logical reasons for it being present.
3. Ask the client to develop and process a list of key past and present life conflicts that continue to cause worry.
4. Assist the client in becoming aware of key unresolved life conflicts and in starting to work toward their resolution.
5. Reinforce the client's insights into the role of his/her past emotional pain and present anxiety.
6. Assign the client to complete the anxiety section exercises in *Ten Days to Self-Esteem!* (Burns) that

reveal cognitive distortions; process the completed assignments.

4. Complete a psychiatric evaluation for medications. (7)
7. Refer the client to a physician for a psychotropic medication consultation.

5. Take medications as prescribed and report any side effects to appropriate professionals. (8)
8. Monitor the client's psychotropic medication compliance, side effects, and effectiveness; confer regularly with the physician.

6. Implement appropriate relaxation and diversion activities to decrease level of anxiety. (9, 10, 11)
9. Train the client in a guided imagery technique to be used for anxiety relief.
10. Utilize biofeedback techniques to facilitate the client's relaxation skills.
11. Assign or allow the client to choose a chapter in *Relaxation and Stress Reduction Workbook* (Davis, Eshelman, and McKay); encourage implementation of the chosen stress reduction technique.

7. Increase daily social and vocational involvement. (12)
12. Assist the client in developing behavioral coping and distraction strategies (e.g., increased social involvement, obtaining employment, physical exercise) for his/her anxiety.

8. Acknowledge the irrational nature of the fears. (13, 14, 15)
13. Assist the client in developing an awareness of the irrational nature of his/her fears.
14. Analyze the client's fear by examining the probability of the negative expectation occurring, the real

consequences of it occurring, his/her ability to control the outcome, the worst possible outcome, and his/her ability to accept it. (See *Anxiety Disorders and Phobias* by Beck and Emery).

15. Explore the irrational cognitive messages that mediate the client's anxiety response and retrain him/her in adaptive cognitions.

9. Report a decreased daily level of anxiety due to the use of positive self-talk. (16)

16. Help the client develop reality-based, positive cognitive messages that will increase his/her self-confidence in coping with irrational fears.

10. Implement a thought-stopping technique to interrupt anxiety-producing thoughts. (17)

17. Teach the client to implement a thought-stopping technique (thinking of a stop sign and then a pleasant scene) that cognitively interferes with obsessions; monitor and encourage the client's use of the technique in daily life between sessions.

11. List the advantages and disadvantages of the anxiety. (18)

18. Ask the client to complete the Cost Benefit Analysis exercise in *Ten Days to Self-Esteem!* (Burns), in which he/she lists the advantages and disadvantages of the negative thought, fear, or anxiety; process the completed assignment.

12. Verbalize alternative positive views of reality that are incompatible with anxiety-producing views. (19, 20)

19. Read and process with the client a fable from *Friedman's Fables* (Friedman) that pertains to anxiety.

20. Reframe the client's fear or anxiety by offering another way of looking at it, various alternatives, or by enlarging the perspective.

13. Identify an anxiety coping mechanism that has been successful in the past and increase its use. (21)

21. Utilize a brief solution-focused therapy approach in which the client is probed to find a time or situation in his/her life when he/she handled the specific anxiety or an anxiety in general. Clearly focus the approach he/she used and then encourage the client to increase its use. Monitor, and modify the solution as required.

14. Utilize a paradoxical intervention technique to reduce the anxiety response. (22)

22. Develop a paradoxical intervention (see *Ordeal Therapy* by Haley) in which the client is encouraged to have the problem (e.g., anxiety) and then schedule that anxiety to occur at specific intervals each day in a specific way and for a defined length of time. (It is best to have it happen at a time of day/night when the client would be clearly wanting to do something else.)

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.02	Generalized Anxiety Disorder
	300.0	Anxiety Disorder NOS
	309.24	Adjustment Disorder With Anxiety
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	_____	_____

ATTENTION DEFICIT DISORDER (ADD)—ADULT

BEHAVIORAL DEFINITIONS

1. Childhood history of Attention Deficit Disorder (ADD) that was either diagnosed or later concluded due to the symptoms of behavioral problems at school, impulsivity, temper outbursts, and lack of concentration.
2. Unable to concentrate or pay attention to things of low interest, even when those things are important to his/her life.
3. Easily distracted and drawn from task at hand.
4. Restless and fidgety; unable to be sedentary for more than a short time.
5. Impulsive; has an easily observable pattern of acting first and thinking later.
6. Rapid mood swings and mood liability within short spans of time.
7. Disorganized in most areas of his/her life.
8. Starts many projects but rarely finished any.
9. Has a "low boiling point and a short fuse."
10. Exhibits low stress tolerance; is easily frustrated, hassled, or upset.
11. Chronic low self-esteem.
12. Tendency toward addictive behaviors.

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LONG-TERM GOALS

1. Reduce impulsive actions while increasing concentration and focus on low-interest activities.
2. Minimize ADD behavioral interference in daily life.
3. Accept ADD as a chronic issue and need for continuing medication treatment.
4. Sustain attention and concentration for consistently longer periods of time.
5. Achieve a satisfactory level of balance, structure, and intimacy in personal life.

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SHORT-TERM OBJECTIVES

1. Cooperate with and complete psychological testing. (1)

2. Cooperate with and complete a psychiatric evaluation. (2)

3. Comply with all recommendations based on the psychiatric and/or psychological evaluations. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Arrange for the administration of psychological testing to the client to establish or rule out Attention-Deficit/Hyperactivity Disorder (ADHD); provide feedback as to testing results.
2. Arrange for a psychiatric evaluation of the client to assess his/her need for psychotropic medication.
3. Process the results of the psychiatric evaluation and/or psychological testing with the client and answer any questions that may arise.
4. Conduct a conjoint session with significant others and

	the client to present the results of the psychological and psychiatric evaluations. Answer any questions they may have and solicit their support in dealing with the client's condition.
4. Take medication as prescribed, on a regular, consistent basis. (5, 6)	5. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medications on his/her level of functioning. 6. Confer with the client's psychiatrist on a regular basis regarding the effectiveness of the medication regime.
5. Identify specific benefits of taking prescribed medications on a long-term basis. (7, 8, 9)	7. Ask the client to make a "pros and cons" spreadsheet regarding staying on medications after doing well; process the results. 8. Encourage and support the client in remaining on medications and warmly but firmly confront thoughts of discontinuing when they surface. 9. Assign the client to list the positive effects that have occurred for him/her since starting on medication.
6. Read material that is informative regarding ADD to gain knowledge about the condition. (10)	10. Ask the client to read material on ADD (e.g., *Driven to Distraction* by Hallowell and Raty, *The Hyperactive Child, Adolescent and Adult* by Wender, *Putting on the Brakes* by Quinn and Stern; or *You Mean I'm Not Lazy, Stupid or Crazy* by Kelly

and Ramundo); process the material read.

7. Identify the specific ADD behaviors that cause the most difficulty. (11, 12, 13)

11. Assist the client in identifying the specific behaviors that cause him/her the most difficulty.

12. Review the results of psychological testing and/or psychiatric evaluation again with the client assisting in identifying or in affirming his/her choice of the most problematic behavior(s) to address.

13. Ask the client to have extended family members and close collaterals complete a ranking of the three behaviors they see as interfering the most with his/her daily functioning (e.g., mood swings, temper outbursts, easily stressed, short attention span, never completes projects).

8. List the negative consequences of the ADD problematic behavior. (14)

14. Assign the client to make a list of negative consequences that he/she has experienced or that could result from a continuation of the problematic behavior; process the list.

9. Apply problem-solving skills to specific ADD behaviors that are interfering with daily functioning. (15, 16)

15. Teach the client problem-solving skills (i.e., identify problem, brainstorm all possible options, evaluate each option, select best option, implement course of action, and evaluate results) that can be applied to his/her ADD behaviors.

16. Assign problem-solving homework to the client specific to the identified behavior (i.e., impulse control, anger outbursts, mood swings, staying on task, attentiveness); process the completed assignment and give appropriate feedback to the client.

10. Utilize cognitive strategies to curb impulsive behavior. (17)

17. Teach the client the self-control strategies of "stop, listen, think, act" and "problem-solving self-talk." Role-play these techniques to improve his/her skill level.

11. Implement a specific, time-limited period if indulging impulses that are not self-destructive. (18)

18. Structure a "blowout" time each week when the client can do whatever he/she likes to do that is not self-destructive (e.g., blast themselves with music, gorge on ice cream).

12. Use "time out" to remove self from situations and think about behavioral reaction alternatives and their consequences. (19)

19. Train the client to use a "time-out" intervention in which he/she settles down by going away from the situation and calming down to think about behavioral alternatives and their consequences.

13. Implement relaxation procedures to reduce tension and physical restlessness. (20)

20. Instruct the client in various relaxation techniques (e.g., deep breathing, meditation, guided imagery) and encourage him/her to use them daily or when stress increases.

14. Reward self when impulsivity, inattention, or forgetfulness are replaced by positive alternatives. (21, 22)

21. Design and implement a self-administered reward system to reinforce and encourage the client's

decreased impulsiveness, loss of temper, inattentiveness, etc.

22. Teach the client to utilize external structure (e.g., lists, reminders, files, daily rituals) to reduce the effects of his/her inattention and forgetfulness; encourage the client to reward himself/herself for successful recall and follow-through.

15. Cooperate with brainwave biofeedback to improve impulse control and reduce distractibility. (23, 24)

23. Refer for or administer brainwave biofeedback to improve attention span, impulse control, and mood regulation.

24. Encourage the client to transfer the biofeedback training skills of relaxation and cognitive focusing to everyday situations (e.g., home, work, social).

16. Report a decrease in statements and feelings of negativity regarding self and life. (25)

25. Conduct conjoint sessions in which positive aspects of the relationship, the client, and significant other are identified and affirmed.

17. Introduce behaviors into life that improve health and/or serve others. (26, 27)

26. Direct the client toward healthy addictions (e.g., exercise, volunteer work, community service).

27. After clearance from the client's personal physician, refer client to a physician fitness trainer who can design an aerobic exercise routine for him/her.

18. Attend an ADD support group. (28)

28. Refer the client to a specific group therapy for adults with ADD to increase the

client's understanding of ADD, to boost his/her self-esteem, and to obtain feedback from others.

19. Use a "coach" who has been trained by therapist to increase organization and task focus. (29, 30)

29. Direct the client to pick a "coach" who is a friend or colleague to assist him/her in getting organized and staying on task and to provide encouragement support (see *Driven to Distraction* by Hallowell and Raty).

30. Instruct the coach in HOPE technique (i.e., Help, Obligations, Plans, and Encouragement) as described in *Driven to Distraction* by Hallowell and Raty).

20. Report improved listening skills without defensiveness. (31)

31. Use role-playing and modeling to teach the client how to listen and accept feedback from others regarding his/her behavior.

21. Have significant other attend an ADD support group to increase his/her understanding of the condition. (32)

32. Educate the client's significant other on ADD and encourage him/her to attend a support group.

22. Report improved communication, understanding, and feelings of trust between self and significant other. (33, 34, 35, 36)

33. Ask the client and significant other to list the expectations they have for the relationship and each other. Process the list in conjoint session with a focus on identifying how the expectations can be met and how realistic they are.

34. Assist the client and his/her significant other in removing blocks in their commu-

nication and in developing new communication skills.

35. Refer the client and significant other to a skill-based marriage/relationship seminar (e.g., PREP, Marriage Encounter, Engaged Encounter) to improve communication and conflict resolution skills.

36. Assign the client and significant other to schedule a specific time each day to devote to communicating together, expressing affection, having fun, or talking through problems. Move assignment toward becoming a daily ritual.

23. Develop a signal to act as a warning system to indicate when anger levels are escalating with the partner. (37)

37. Assist the client and significant other in developing a signal system as a means of giving feedback when conflict behaviors and anger begin to escalate.

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DIAGNOSTIC SUGGESTIONS

Axis I:	314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
	314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
	314.9	Attention-Deficit/Hyperactivity Disorder NOS

296.xx	Bipolar I Disorder
301.13	Cyclothymic Disorder
296.90	Mood Disorder NOS
312.30	Impulse-Control Disorder NOS
303.90	Alcohol Dependence
305.0	Alcohol Abuse
304.30	Cannabis Dependence
305.20	Cannabis Abuse
_____	_____
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BORDERLINE PERSONALITY

BEHAVIORAL DEFINITIONS

1. A minor stress leads to extreme emotional reactivity (anger, anxiety, or depression) that usually lasts from a few hours to a few days.
2. A pattern of intense, chaotic interpersonal relationships.
3. Marked identity disturbance.
4. Impulsive behaviors that are potentially self-damaging.
5. Recurrent suicidal gestures, threats, or self-mutilating behavior.
6. Chronic feelings of emptiness and boredom.
7. Frequent eruptions of intense, inappropriate anger.
8. Easily feels unfairly treated and believes that others can't be trusted.
9. Analyzes most issues in simple terms (e.g., right/wrong, black/white, trustworthy/deceitful) without regard for extenuating circumstances or complex situations.
10. Becomes very anxious with any hint of perceived abandonment in a relationship.

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LONG-TERM GOALS

1. Develop and demonstrate coping skills to deal with mood swings.
2. Develop the ability to control impulsive behavior.

3. Replace dichotomous thinking with the ability to tolerate ambiguity and complexity in people and issues.
4. Develop and demonstrate anger management skills.
5. Learn and practice interpersonal relationship skills.
6. Terminate self-damaging behaviors (such as substance abuse, reckless driving, sexual acting out, binge eating, or suicidal behaviors).

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SHORT-TERM OBJECTIVES

1. Verbalize the situations that can easily trigger feelings of fear, depression, and anger. (1, 2)

2. Identify the negative, distorted cognitions that mediate intense negative emotions. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Explore the client's situations that trigger feelings of fear, depression, and anger.
2. Assign the client to record a daily journal of feelings along with the circumstances that he/she was reacting to; process the journal material to identify triggers for emotional reactivity.
3. Assist the client in identifying the distorted schemas and related automatic thoughts that mediate his/her anxiety response.
4. Require the client to keep a daily record of self-defeating thoughts (e.g., regarding hopelessness, helplessness, worthlessness, catastrophizing, negatively predicting the future); challenge each thought for

accuracy, then replace each dysfunctional thought with one that is positive and self-enhancing.

3. Verbalize realistic, positive self-talk to replace distorted negative messages. (5, 6, 7)

5. Train the client in revising core schema using cognitive restructuring techniques.
6. Reinforce the client's positive, realistic cognitive self-talk that mediates a sense of peace.
7. Assign the client to record instances of successfully using revised, constructive cognitive patterns; process and reinforce positive consequences.

4. List some negative consequences to self and others of self-defeating, impulsive behaviors. (8)

8. Assign the client to list the destructive consequences of his/her impulsive behavior to self and others.

5. Utilize cognitive methods to control impulsive behavior. (9, 10, 11)

9. Teach the client mediational and self-control strategies (e.g., "stop, look, listen, and think") to delay gratification and inhibit impulses.
10. Assign the client to record instances of successfully implementing "stop, look, listen, and think" to control reactive impulses; process and reinforce the successes.
11. Teach the client cognitive methods (e.g., thought stoppage, thought substitution, reframing) for gaining and improving control over impulsive actions; encourage implementation in daily life.

6. Record and report instances of using relaxation techniques to manage intense feelings and control impulsive reactive behavior. (12, 13)

12. Using techniques such as progressive relaxation, self-hypnosis, or biofeedback, teach the client how to relax completely; then encourage the client to relax whenever he/she feels uncomfortable.
13. Ask the client to record instances of using relaxation techniques to cope with stress rather than reacting with anger; reinforce successful implementation of this coping skill.

7. Implement assertiveness and describe the consequences. (14, 15, 16)

14. Use role-playing, modeling, and behavioral rehearsal to teach the client assertiveness (versus passivity and aggressiveness).
15. Refer the client to an assertiveness training group.
16. Review the client's implementation of assertiveness and his/her feelings about it as well as the consequences of it; reinforce success and redirect for failure.

8. Implement the use of "I messages" to communicate feelings without aggression. (17, 18)

17. Use modeling, role-playing, and behavioral rehearsal to teach the client the use of "I messages" to communicate feelings directly (i.e., I feel . . . When you . . . I would prefer it if you . . .).
18. Reinforce the client's reported use of "I messages" in place of aggressiveness or possessiveness when feeling threatened.

9. Verbalize the impact that childhood experiences of abuse, neglect, or abandonment have upon current feelings and relationships. (19, 20, 21)

19. Explore instances of abuse, neglect, or emotional/physical abandonment in the client's childhood; process the feelings associated with these experiences.

20. Point out to the client the destructive effect of overcontrol of others and angry resentment when others pull back from relationships. Encourage separation of helpless, desperate feelings of the past from current relationships.

21. Reinforce the client's insight into the effect of childhood experiences of neglect or abuse on current urges to react with rage or possessiveness.

10. List and implement coping strategies to deal with fear of abandonment. (22)

22. Teach the client to use coping strategies (e.g., delay of reaction, "stop, look, listen, and plan," relaxation and deep breathing techniques, "I messages," expanded social network versus few intense relationships) to deal with fear of abandonment; process his/her implementation of these strategies in daily life.

11. Initiate enjoyable activities that can be done alone. (4, 23, 24)

4. Require the client to keep a daily record of self-defeating thoughts (e.g., regarding hopelessness, helplessness, worthlessness, catastrophizing, negatively predicting the future); challenge each thought for accuracy, then replace each

	dysfunctional thought with one that is positive and self-enhancing.
	23. Explore the client's automatic thoughts associated with being alone.
	24. Encourage the client to break his/her pattern of avoiding being alone by initiating activities without a companion (e.g., starting a hobby; exercising; attending lectures, concerts, movies; reading a book; taking a class).
12. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (25)	25. Refer the client to a physician to evaluate his/her need for a psychotropic medication to stabilize mood.
13. Take medication as prescribed and report as to effectiveness and side effects. (26)	26. Monitor and evaluate the client's psychotropic medication prescription compliance, effectiveness, and side effects.
14. Verbalize the intense feelings that motivate self-mutilating behavior and how those feelings are relieved by such behavior. (19, 21, 27, 28)	19. Explore instances of abuse, neglect, or emotional/physical abandonment in the client's childhood; process the feelings associated with these experiences.
	21. Reinforce the client's insight into the effect of childhood experiences of neglect or abuse on current urges to react with rage or possessiveness.
	27. Probe the nature and history of the client's self-mutilating behavior.

15. Verbalize a promise to contact the therapist or some other emergency helpline if a serious urge toward self-harm arises. (29, 30, 31, 32)

16. List negative consequences of judging people rigidly and harshly. (33, 34)

28. Interpret the client's self-mutilation as an expression of the rage and helplessness that could not be expressed as a child victim of emotional abandonment or abuse.

29. Assess the client's suicidal gestures as to triggers, frequency, seriousness, secondary gain, and onset.

30. Elicit a promise (as part of a self-mutilation and suicide prevention contract) from the client that he/she will initiate contact with the therapist or a helpline if a suicidal urge becomes strong and before any self-injurious behavior occurs.

31. Provide the client with an emergency helpline telephone number that is available 24 hours a day.

32. Encourage the client to express his/her feelings directly using assertive "I messages" rather than indirectly through self-mutilating behavior.

33. Assist the client in examining his/her style of evaluating people, especially with regard to his/her dichotomous thinking.

34. Teach the client the alienating consequences of judging people harshly and impulsively.

17. Verbalize weaknesses or faults of those who have been judged to be perfect, and strengths or assets of those people who have been judged to be evil, worthless, and deceitful. (35, 36)

35. Challenge the client in understanding how dichotomous thinking leads to feelings of interpersonal mistrust.

36. Use role reversal and modeling to assist the client in seeing positive and negative qualities in all people.

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.4	Dysthymic Disorder
	296.3x	Major Depressive Disorder, Recurrent
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

CHEMICAL DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Consistent use of alcohol or other mood-altering drugs until high, intoxicated, or passed out.
2. Inability to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Blood work that reflects the results of a pattern of heavy substance use (e.g., elevated liver enzymes).
4. Denial that chemical dependence is a problem despite direct feedback from spouse, relatives, friends, and employers that the use of the substance is negatively affecting them and others.
5. Amnestic blackouts occur when abusing alcohol.
6. Continued drug and/or alcohol use despite experiencing persistent or recurring physical, legal, vocational, social, or relationship problems that are directly caused by the use of the substance.
7. Increased tolerance for the drug as evidenced by the need to use more to become intoxicated or to attain the desired effect.
8. Physical symptoms (i.e., shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, and/or depression) when withdrawing from the substance.
9. Suspension of important social, recreational, or occupational activities because they interfere with using the mood-altering drug.
10. Large time investment in activities to obtain the substance, to use it, or to recover from its effects.
11. Consumption of a mood-altering substance in greater amounts and for longer periods than intended.
12. Continued abuse of a mood-altering chemical after being told by a physician that it is causing health problems.

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LONG-TERM GOALS

1. Accept fact of chemical dependence and begin to actively participate in a recovery program.
2. Establish a sustained recovery, free from the use of all mood-altering substances.
3. Establish and maintain total abstinence while increasing knowledge of the disease and the process of recovery.
4. Acquire the necessary skills to maintain long-term sobriety from all mood-altering substances.
5. Improve quality of personal life by maintaining an ongoing abstinence from all mood-altering chemicals.
6. Withdraw from mood-altering substance, stabilize physically and emotionally, and then establish a supportive recovery plan.

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SHORT-TERM OBJECTIVES

1. Describe the amount, frequency, and history of substance abuse. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her use, signs and symptoms of use, and negative life consequences (e.g., social, legal, familial, vocational).

	2. Administer to the client an objective test of drug and/or alcohol abuse (e.g., the Alcohol Severity Index, the MAST); process the results with the client.
2. Obtain a medical examination to evaluate the effects of chemical dependence. (3)	3. Refer the client for thorough physical examination to determine any physical effects of chemical dependence.
3. Identify the negative consequences of drug and/or alcohol abuse. (3, 4)	3. Refer the client for thorough physical examination to determine any physical effects of chemical dependence. 4. Ask the client to make a list of the ways substance abuse has negatively impacted his/her life and process it with him/her.
4. Decrease the level of denial around using as evidenced by fewer statements about minimizing amount of use and its negative impact on life. (5, 6)	5. Assign the client to ask two or three people who are close to him/her to write a letter to therapist in which they identify how they saw the client's chemical dependence negatively impacting his/her life. 6. Assign the client to complete a First Step paper and then to process it with group, sponsor, or therapist to receive feedback.
5. Make verbal "I" statements that reflect a knowledge and acceptance of chemical dependence. (7)	7. Model and reinforce statements that reflect the client's acceptance of his/her chemical dependence and its destructive consequences for self and others.
6. Verbalize increased knowledge of alcoholism and the process of recovery. (8, 9)	8. Require the client to attend didactic lectures related to chemical dependence and the process of recovery.

Then ask the client to identify in writing several key points attained from each lecture for further processing with therapist.

9. Assign the client to read an article/pamphlet on the disease concept of alcoholism and to select several key ideas to discuss with therapist.

7. Verbalize a commitment to abstain from the use of mood-altering drugs. (10, 11)

10. Develop an abstinence contract with the client regarding the termination of the use of his/her drug of choice.

11. Direct the client to write a good-bye letter to drug of choice; read it and process related feelings with therapist.

8. Attend Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings on a regular basis as frequently as necessary to support sobriety. (12, 13)

12. Assign the client to meet with an AA/NA member who has been working the Twelve-Step program for several years and find out specifically how the program has helped him/her to stay sober; afterward, process the meeting.

13. Recommend that the client attend AA or NA meetings and report on the impact of the meetings.

9. Verbalize an understanding of personality, social, and family factors, including childhood experiences, that foster chemical dependence. (14, 15, 16)

14. Assess the client's intellectual, personality, and cognitive functioning as to their contribution to his/her chemical dependence.

15. Investigate situational stress factors that may foster the client's chemical dependence.

16. Probe the client's family history for chemical dependence patterns and relate these to his/her use.

10. Review extended family alcohol use history and verbalize an acceptance of a genetic component to chemical dependence. (17)

17. Explore extended family chemical dependence and relate this to a genetic vulnerability for the client to also develop chemical dependence.

11. Identify the ways being sober could positively impact life. (18)

18. Ask the client to make a list of how being sober could positively impact his/her life; process the list.

12. State changes that will be made in social relationships to support recovery. (19, 20)

19. Review the negative influence of the client continuing his/her alcohol-related friendships ("drinking buddies") and assist him/her in making a plan to develop new sober relationships.

20. Assist the client in developing insight into life changes needed in order to maintain long-term sobriety.

13. Identify projects and social and recreational activities that sobriety will now afford the time and energy to do. (21, 22)

21. Assist the client in planning social and recreational activities that are free from association with substance abuse.

22. Plan household or work-related projects that can be accomplished to build the client's self-esteem now that sobriety affords time and energy for such constructive activity.

14. Verbalize how living situation contributes to chemical dependence and acts as a hindrance to recovery. (23, 24)

23. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence.

15. Make arrangements to terminate current living situation and move to a place more conducive to recovery. (25, 26)

16. Identify the positive impact that sobriety will have on intimate and family relationships. (27)

17. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (28, 29)

18. Identify sources of ongoing support in maintaining sobriety. (30)

19. Identify potential relapse triggers and develop strategies for constructively dealing with each trigger. (31, 32)

24. Assign the client to write a list of the negative influences for chemical dependence inherent in his/her living situation.

25. Encourage a plan for the client to change his/her living situation in order to foster recovery.

26. Reinforce the client's positive change in living situation.

27. Assist the client in identifying positive changes that will be made in family relationships during recovery.

28. Discuss the negative effects the client's substance abuse has had on family, friends, and work relationships and encourage a plan to make amends for such hurt.

29. Elicit from the client a verbal commitment to make initial amends now to key individuals and further amends when working steps Eight and Nine of AA program.

30. Explore with the client the positive support system personally available in sobriety and discuss ways to develop and reinforce a positive support system.

31. Help the client develop an awareness of relapse triggers and alternative ways of effectively handling them.

32. Recommend that the client read material on how to avoid relapse (e.g., *Staying Sober: A Guide to Relapse Prevention* by Gorski and Miller and *The Staying Sober Workbook* by Gorski).

20. Develop a written aftercare plan that will support the maintenance of long-term sobriety. (33)

33. Assign and review the client's written aftercare plan to ensure it is adequate to maintain sobriety.

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DIAGNOSTIC SUGGESTIONS

Axis I:	303.90	Alcohol Dependence
	305.0	Alcohol Abuse
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	305.60	Cocaine Abuse
	304.80	Polysubstance Dependence
	291.2	Alcohol-Induced Persisting Dementia
	291.1	Alcohol-Induced Persisting Amnestic Disorder
	V71.01	Adult Antisocial Behavior
	300.4	Dysthymic Disorder
	312.34	Intermittent Explosive Disorder
	309.81	Posttraumatic Stress Disorder
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	_____	_____
	_____	_____

CHEMICAL DEPENDENCE—RELAPSE

BEHAVIORAL DEFINITIONS

1. Inability to remain abstinent from mood-altering drugs after receiving treatment for substance abuse.
2. Inability to stay sober even though attending Alcoholics Anonymous (AA) meetings regularly.
3. Relapse into abuse of mood-altering substances after a substantial period of sobriety.
4. Chronic pattern of period of sobriety (six months plus) followed by a relapse, then reestablishing sobriety.

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LONG-TERM GOALS

1. Establish a consistently alcohol/drug-free lifestyle.
2. Develop an understanding of personal pattern of relapse in order to help sustain long-term recovery.
3. Develop an increased awareness of relapse triggers and the coping strategies needed to effectively deal with them.
4. Achieve a quality of life that is substance-free on a continuing basis.

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SHORT-TERM OBJECTIVES

1. Verbalize a commitment to abstinence/sobriety. (1, 2)

2. Outline and implement a daily routine that is structured and includes AA involvement. (3, 4)

3. Reestablish ongoing relationships with people who are supportive of sobriety. (5, 6)

THERAPEUTIC INTERVENTIONS

1. Discuss with the client the specific behaviors, attitudes, and feelings that led up to the last relapse, focusing on triggers for the relapse. Obtain a clear, firm commitment to renewed sobriety.
2. Assess the client for ability to reestablish total abstinence and refer to more intense level of care if he/she is not able to detox and stay sober.
3. Teach the importance of structure and routine that have either been abandoned or never been present in the client's daily life and then assist the client in developing and implementing a balanced, structured daily routine.
4. Urge the client to attend AA consistently as a part of the routine structure of his/her life.
5. Assist the client in reuniting with his/her AA sponsor.
6. Ask the client to find a second AA/NA sponsor who is an opposite of the primary

	sponsor (e.g., if the primary is mainly supportive, seek another who is more confrontive) and meet regularly with both sponsors on at least a weekly basis.
4. Verbalize feelings about the loss of sobriety. (7, 8)	7. Assist the client in expanding his/her ability to identify feelings, process them, and then express them in a timely, healthy way. 8. Assign the client to read *The Golden Book of Resentment* (Father John Doe) or readings on resentment from *As Bill Sees It* (Bill Wilson); choose three key concepts that he/she feels relate to him/her; and process them together.
5. Identify people and places to be avoided to maintain recovery. (9, 10)	9. Assist the client in identifying the negative influence of people and situations that encourage relapse, and ways to avoid them. 10. Assign the client to read a book or pamphlet on recovery. Select items from it that relate to him/her and process them together.
6. Identify the specific behaviors, attitudes, and feelings that led up to the last relapse, focusing on triggers for the relapse. (11, 12, 13, 14)	11. Assign the client to complete a relapse workbook (e.g., *The Staying Sober Workbook* by Gorski), and process it with him/her. 12. Assign the client to do a focused autobiography dating from his/her first attempt to get sober to the present. Then have him/her read it aloud for feedback as to triggers for relapse.

13. Ask the client to gather from significant others an observation list of the client's behavior or attitudes prior to his/her returning to using; process the feedback in group therapy or in individual session.
14. Develop a symptom line with the client that looks at each relapse in terms of when it happened (i.e., time of year, dates, and their significance) and what was occurring in regard to self, spouse, family, work, and social activities.

7. Identify behavior patterns that will need to be changed to maintain sobriety. (15, 16)

15. Ask the client to develop a list of behaviors, attitudes, and feelings that could have been involved in the relapse, and process it with him/her.
16. Assign the client to read *Many Roads, One Journey: Moving Beyond the 12 Steps* (Kasl-Davis) or *Stage II Recovery* (Larsen), and process the key ideas with him/her.

8. Identify positive rewards associated with abstinence. (17, 18)

17. Assist the client in identifying positive rewards of total abstinence.
18. Assign the client to complete and process with therapist a "Cost-Benefit Analysis" (see *Ten Days to Self-Esteem!* by Burns) on his/her return to substance abuse.

9. Complete medical assessment for Antabuse or antidepressant medications. (19)
10. Cooperate with acupuncturist for treatment to reduce the urge to use mood-altering substances. (20)
11. Comply with medication recommendations as prescribed and report any side effects to the therapist and/or physician. (21, 22)
12. Verbalize insights learned from talking and listening to successfully recovering chemically dependent people. (23)
13. Meet with a spiritual leader to make progress on AA Steps Two, Three, and Five. (24)
14. Report increased tolerance for uncomfortable emotions. (25, 26)

19. Refer the client to physician/psychiatrist for an evaluation for Antabuse or antidepressant medication.
20. Refer the client to acupuncturist for treatment on a regular basis and monitor effectiveness.
21. Monitor the client for compliance with medication orders or other treatments and possible side effects, and answer any questions he/she may have.
22. Confer with the prescribing physician on a regular basis regarding the effectiveness of the treatment.
23. Ask the client to interview NA/AA members who have been sober for three or more years, focusing on what they have specifically done to accomplish this, and if they have relapsed, what they have done to get back on track to stay. Process the client's findings with him/her.
24. Refer the client to a pastor, rabbi, priest, or other spiritual leader with knowledge of substance abuse and recovery to work through any blocks regarding Steps Two and Three or to complete Step Five.
25. Teach the client various methods of stress reduction (e.g., meditation, deep

	breathing, positive imagery) and assist him/her in implementing them into daily life.
	26. Ask the client to develop a list of ways of coping with uncomfortable feelings; process the list with him/her.
15. Implement assertiveness skills to communicate feelings directly. (27)	27. Assist the client in developing assertiveness techniques.
16. Develop in writing two possible coping strategies for each specific relapse trigger. (26, 28)	26. Ask the client to develop a list of ways of coping with uncomfortable feelings; process the list with him/her.
	28. Assist the client in developing two coping strategies for each identified trigger to relapse.
17. Verbally describe the family and relationship conflicts that played a role in triggering relapse. (29)	29. Conduct conjoint and/or family sessions that identify and resolve relationship stress that has served as a trigger for relapse.
18. The spouse or significant other verbalize an understanding of constructive actions that can be taken in reaction to the client's relapse and recovery. (30)	30. Conduct sessions with spouse or significant other to educate him/her regarding relapse triggers and instruct them on how to be supportive of sobriety. Encourage him/her to attend Alanon on a regular basis.
19. Participate in rituals that support recovery. (31)	31. Assist the client in developing and establishing rituals in life that will enhance sobriety and be a deterrent to relapse (e.g., receiving AA/NA coins, regular membership in a Step Study Group, coffee with sponsor at set date and time).

20. Identify successful sober living strategies of the past. (32)

21. Verbalize principles to live by that will support sobriety. (33)

22. Develop written continuing aftercare plan with focus on coping with family and other stressors. (34, 35)

32. Utilize a brief solution-focused approach with the client to identify specific things he/she did when sobriety was going well and then select and direct the client to increase the use of the identified behaviors. Monitor and adjust direction as needed.

33. Assign the client to read a fable or story such as "The Boy Who Lost His Way," "The Prodigal Son," or "Three Little Pigs" (see *Stories For the 3rd Ear,* by Wallas), and then process it together to identify key concepts connected to staying sober.

34. Ask the client to complete and process a relapse contract with significant other that identifies previous relapse-associated behaviors, attitudes, and emotions, coupling them with agreed-upon warnings from significant other as they are observed.

35. Assign the client to develop and process a written aftercare plan that specifically addresses previously identified relapse triggers.

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DIAGNOSTIC SUGGESTIONS

Axis I:	303.90	Alcohol Dependence
	305.0	Alcohol Abuse
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	304.80	Polysubstance Dependence
	291.2	Alcohol-Induced Persisting Amnestic Disorder
	300.4	Dysthymic Disorder
	309.81	Posttraumatic Stress Disorder
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	_____	_____
	_____	_____

CHILDHOOD TRAUMAS

BEHAVIORAL DEFINITIONS

1. Reports of childhood physical, sexual, and/or emotional abuse.
2. Description of parents as physically or emotionally neglectful as they were chemically dependent, too busy, absent, etc.
3. Description of childhood as chaotic as parent(s) was substance abuser (or mentally ill, antisocial, etc.), leading to frequent moves, multiple abusive spousal partners, frequent substitute caretakers, financial pressures, and/or many stepsiblings.
4. Reports of emotionally repressive parents who were rigid, perfectionist, threatening, demeaning, hypercritical, and/or overly religious.
5. Irrational fears, suppressed rage, low self-esteem, identity conflicts, depression, or anxious insecurity related to painful early life experiences.
6. Dissociation phenomenon (multiple personality, psychogenic fugue or amnesia, trance state, and/or depersonalization) as a maladaptive coping mechanism resulting from childhood emotional pain.

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LONG-TERM GOALS

1. Develop an awareness of how childhood issues have affected and continue to affect one's family life.

2. Resolve past childhood/family issues, leading to less anger and depression, greater self-esteem, security, and confidence.
3. Release the emotions associated with past childhood/family issues, resulting in less resentment and more serenity.
4. Let go of blame and begin to forgive others for pain caused in childhood.

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SHORT-TERM OBJECTIVES

1. Describe what it was like to grow up in the home environment. (1, 2)
2. Describe each family member and identify the role each played within the family. (2, 3)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
2. Develop the client's family genogram and/or symptom line and help identify patterns of dysfunction within the family.
2. Develop the client's family genogram and/or symptom line and help identify patterns of dysfunction within the family.
3. Assist the client in clarifying his/her role within the family and his/her feelings connected to that role.

3. Identify patterns of abuse, neglect, or abandonment within the family of origin, both current and historical, nuclear and extended. (4, 5)

4. Identify feelings associated with major traumatic incidents in childhood and with parental child-rearing patterns. (6, 7, 8)

5. Identify how own parenting has been influenced by childhood experiences. (9)

6. Acknowledge any dissociative phenomena that have resulted from childhood trauma. (10, 11)

4. Assign the client to ask parents about their family backgrounds and develop insight regarding patterns of behavior and causes for parents' dysfunction.

5. Explore the client's painful childhood experiences.

6. Support and encourage the client when he/she begins to express feelings of rage, sadness, fear, and rejection relating to family abuse or neglect.

7. Assign the client to record feelings in a journal that describes memories, behavior, and emotions tied to his/her traumatic childhood experiences.

8. Ask the client to read books on the emotional effects of neglect and abuse in childhood (e.g., *It Will Never Happen To Me* by Black, *Outgrowing the Pain* by Gil, *Healing the Child Within* by Whitfield, and *Why I'm Afraid to Tell You Who I Am* by Powell); process insights attained.

9. Ask the client to compare his/her parenting behavior to that of parent figures of his/her childhood; encourage the client to be aware of how easily we repeat patterns that we grew up with.

10. Assist the client in understanding the role of dissociation in protecting himself/herself from the

pain of childhood abusive betrayals. (See Dissociation chapter in this Planner).

11. Assess the severity of the client's dissociation phenomena and hospitalize as necessary for his/her protection.

7. State the role substance abuse has in dealing with emotional pain of childhood. (12)

12. Assess the client's substance abuse behavior that has developed, in part, as a means of coping with feelings of childhood trauma. If alcohol or drug abuse is found to be a problem, encourage treatment focused on this issue (see the Chemical Dependence chapter of this Planner).

8. Decrease feelings of shame by being able to verbally affirm self as not responsible for abuse. (13, 14, 15, 16)

13. Assign writing a letter to mother, father, or other abuser in which the client expresses his/her feelings regarding the abuse.

14. Hold conjoint sessions where the client confronts the perpetrator of the abuse.

15. Guide the client in an empty chair exercise with a key figure connected to the abuse—that is, perpetrator, sibling, or parent; reinforce the client for placing responsibility for the abuse or neglect on the caretaker.

16. Consistently reiterate that responsibility for the abuse falls on the abusive adults, not the surviving child (for deserving the abuse), and reinforce statements that

accurately reflect placing blame on perpetrators and on nonprotective, nonnurturant adults.

9. Identify the positive aspects for self of being able to forgive all those involved with the abuse. (17, 18, 19)

17. Assign the client to write a forgiveness letter to the perpetrator of abuse; process the letter.
18. Teach the client the benefits (i.e., release of hurt and anger, putting issue in the past, opens door for trust of others, etc.) of beginning a process of forgiveness of (not necessarily forgetting or fraternizing with) abusive adults.
19. Recommend the client read books on the topic of forgiveness (e.g., *Forgive and Forget* by Smedes, *When Bad Things Happen to Good People* by Kushner, etc.).

10. Decrease statements of being a victim while increasing statements that reflect personal empowerment. (20, 21)

20. Ask the client to complete an exercise that identifies the positives and negatives of being a victim and the positives and negatives of being a survivor; compare and process the lists.
21. Encourage and reinforce the client's statements that reflect movement away from viewing self as a victim and toward personal empowerment as a survivor.

11. Increase level of trust of others as shown by more socialization and greater intimacy tolerance. (22, 23)

22. Teach the client the share-check method of building trust in relationships (sharing a little information and checking as to the recipient's

sensitivity in reacting to that information).

23. Teach the client the advantages of treating people as trustworthy given a reasonable amount of time to assess their character.

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.3	Obsessive-Compulsive Disorder
	300.02	Generalized Anxiety Disorder
	309.81	Posttraumatic Stress Disorder
	300.14	Dissociative Identity Disorder
	995.53	Sexual Abuse of Child, Victim
	995.54	Physical Abuse of Child, Victim
	995.52	Neglect of Child, Victim
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.6	Dependent Personality Disorder
	301.4	Obsessive-Compulsive Personality Disorder
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	_____	_____

CHRONIC PAIN

BEHAVIORAL DEFINITIONS

1. Experiences pain beyond the normal healing process (6 months or more) that significantly limits physical activities.
2. Complains of generalized pain in many joints, muscles, and bones that debilitates normal functioning.
3. Overuse or use of increased amounts of medications with little, if any, pain relief.
4. Experiences tension, migraine, cluster, or chronic daily headaches of unknown origin.
5. Experiences back or neck pain, interstitial cystitis, or diabetic neuropathy.
6. Experiences intermittent pain such as that related to rheumatoid arthritis or irritable bowel syndrome.
7. Decreased or stopped activities such as work, household chores, socializing, exercise, sex, or other pleasurable activities because of pain.
8. Experiences an increase in general physical discomfort (e.g., fatigue, night sweats, insomnia, muscle tension, body aches).
9. Exhibits signs and symptoms of depression.
10. Makes statements like "I can't do what I used to"; "No one understands me"; "Why me?"; "When will this go away?;" "I can't take this pain anymore" and "I can't go on."

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LONG-TERM GOALS

1. Acquire and utilize the necessary pain management skills.
2. Regulate pain in order to maximize daily functioning and return to productive employment.
3. Find relief from pain and build renewed contentment and joy in performing activities of everyday life.
4. Find an escape route from the pain.
5. "Make peace with the chronic pain and move on." (Hunter)
6. Lessen daily suffering from pain.
7. Gain control over own life.

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SHORT-TERM OBJECTIVES

1. Describe the nature of, history of, impact of, and understood causes of chronic pain. (1, 2)

2. Complete a thorough medical examination to rule out any alternative causes for the pain and reveal any new treatment possibilities. (3)

THERAPEUTIC INTERVENTIONS

1. Gather a history and current status of the client's chronic pain.
2. Explore the changes in the client's mood, attitude, social, vocational, and familial/marital roles that have occurred in accommodation to pain.
3. Refer the client to a physician or clinic to undergo a thorough examination to rule out any undiagnosed condition and to receive recommendations on any further treatment options.

3. Follow through on a referral to a pain management or rehabilitation program. (4, 5, 6)

4. Give the client information on the options of pain management specialists or rehabilitation programs that are available and help him/her make a decision on which would be the best for him/her.

5. Make a referral to a pain management specialist or clinic of the client's choice and have him/her sign appropriate releases for the therapist to have updates on progress from the program and to coordinate services.

6. Elicit from the client a verbal commitment to cooperate with pain management specialists, headache clinic, or rehabilitation program.

4. Complete a thorough medication review by a physician who is a specialist in dealing with chronic pain or headache conditions. (7)

7. Ask the client to complete a medication review with a specialist in chronic pain or headaches. Confer with the physician afterward about his/her recommendations and process them with the client.

5. Verbalize a statement of ownership of the pain. (8, 9)

8. Assist the client in working through the defenses that prevent him/her from owning the pain as his/hers.

9. Elicit from the client statements of ownership of the pain.

6. Verbalize an increased understanding of pain. (10, 11)

10. Teach the client key concepts of rehabilitation versus biological healing, conservative versus aggressive medical interventions,

acute versus chronic pain, benign versus nonbenign pain, cure versus management, appropriate use of medication, role of exercise and self-regulation techniques, and so on.

11. Assign the client to read books on the place of pain in our lives (e.g., *Pain* by Fields or *The Culture of Pain* by Morris); process key concept/insights gained from the reading.

7. Identify specific non-headache pain triggers. (12, 13)

12. Ask the client to read the chapter on "Identifying Pain Triggers" from *Making Peace with Chronic Pain* (Hunter), then ask him/her to make a list of the triggers that apply to his/her condition; process the list content.

13. Ask the client to keep a pain journal that records time of day, where and what he/she was doing, the severity, and what was done to alleviate the pain. Process the journal with the client to increase insight into nature of the pain, trigger, and what intervention seems to offer the most consistent relief.

8. Identify causes for and triggers of headache pain. (13, 14)

13. Ask the client to keep a pain journal that records time of day, where and what he/she was doing, the severity, and what was done to alleviate the pain. Process the journal with the client to increase insight into nature of the pain, trigger, and

what intervention seems to offer the most consistent relief.

14. Assign the client to read the chapter on "Causes and Triggers" in *Taking Control of Your Headaches* (Duckro, Richardson, and Marshall) or similar information obtained from the National Headache Foundation (800-255-2243).

9. Identify the steps of the "dance of pain" in his/her life. (15)

15. Develop with the client the metaphor of pain as a dance (see *Making Peace with Chronic Pain* by Hunter), working to identify the particular steps of the dance as it moves through his/her daily life. Then challenge the client either to alter the steps of his/her present dance or to design a completely new dance.

10. Verbalize an increased awareness of the mind-body connection. (16, 17)

16. Ask the client to read *Peace, Love, and Healing* (Siegel) or *The Mind/Body Effect* (Benson) or to attend a seminar related to holistic healing for insight into the body-mind connection.

17. Assist the client in beginning to see the connection between chronic pain and chronic stress.

11. Implement the use of relaxation techniques to reduce muscle tension and pain level. (18, 19, 20)

18. Teach the client relaxation techniques (e.g., breathing exercises, using a focus word or phrase, progressive muscle relaxation, creating a safe place, and positive imagery).

19. Encourage the client to use relaxation tapes, videos, and so forth, on a daily basis. Especially recommend "Pachelbel's Canon" by D. Kabialka.
20. Refer for or conduct biofeedback training with the client to increase relaxation skills.

12. Utilize yoga and/or meditation to reduce tension and pain. (21, 22)

21. Ask the client to read *How to Meditate* (LeShan) and then assist him/her in implementing meditation into daily life.
22. Refer the client to a beginners' yoga class.

13. Incorporate physical exercise into daily routine. (23, 24)

23. Assist the client in recognizing his/her need for regular exercise. Then encourage him/her to implement exercise in daily life and monitor results, and offer ongoing encouragement to stay with the regime.
24. Refer the client to an athletic club or a physical therapist to develop an individually tailored exercise program that is approved by his/her personal physician.

14. Identify dysfunctional attitudes about pain that are a foundation for pain being the focus of life. (25, 26)

25. Assign Chapter 6 ("The Power of Mind") and Chapter 7 ("Adopting Healthy Attitudes") from the book *Managing Pain Before It Manages You* (Caudill). Process key concepts gathered from the reading and exercises.
26. Ask the client to gather from several friends, relatives,

	and so on feedback in terms of negative attitudes they see in the client. Process the feedback and identify possible changes he/she could make.
15. Verbalize new, healthier attitudes about pain and life in general. (27, 28)	27. Confront the client's negative attitudes about pain and assist him/her in replacing them with more positive, constructive attitudes.
	28. Assist the client in becoming capable of seeing humor in more of his/her daily life. Promote this expansion with the use of humorous teaching tapes, Dr. Seuss, telling jokes, and assigning the client to watch one or two comedy movies each week.
16. Investigate the use of alternative pain remedies to reduce dependence of doctor visits and/or painkilling medication. (29)	29. Explore the client's alternatives to doctors and medications to remove his/her pain (e.g., acupuncture, hypnosis, or myotheraphy [therapeutic] massage).
17. Make changes in diet that will promote health and fitness. (30)	30. Refer the client to a dietician for consultation around eating and nutritional patterns; process the results of the consultation, identifying changes he/she can make and how he/she might start implementing these changes.
18. Increase the frequency of identified pleasurable activities. (31)	31. Ask the client to create a list of activities that are pleasurable for him/her. Then process list with therapist and develop a plan of increasing the frequency of

the selected pleasurable activities.

19. Increase the frequency of assertive behaviors in becoming more active in managing his/her life. (32)

20. Identify and replace negative self-talk that promotes helplessness, anger, and depression. (33, 34, 35)

21. Identify negative "tapes" and those new positive "tapes" that must replace them. (36)

22. Identify sources of and coping mechanisms for stress in daily life. (37, 38)

32. Train in assertiveness or refer the client to a group that will educate and facilitate assertiveness skills via lectures and assignments.

33. Assign the chapter entitled "You Can Change the Way You Feel" in *The Feeling Good Handbook* (Burns) to assist the client in identifying his/her distorted automatic thoughts that promote depression, helplessness, and/or anger.

34. Assign the client to complete the written exercises in Step 2: "You *Feel* The Way You Think" from *Ten Days to Self Esteem!* (Burns). Process exercises when completed.

35. Assist the client in replacing negative, distorted thoughts with positive, reality-based thoughts.

36. Utilize a Transactional Analysis (TA) approach to help the client become aware of "old tapes," and using the same approach, begin to erase them or create new healthier "tapes."

37. Educate the client on the various types of stressors, then ask him/her to list the stressors he/she experiences in daily life and process the list with the therapist.

38. Assist the client in identifying specific ways to cope

effectively with the major internal, external, and family stressors.

23. Write a thorough, realistic relapse prevention plan. (39, 40)

39. Assist the client in developing a written relapse prevention plan that has a special emphasis on pain- and stress-trigger identification and specific ways to handle each, strengthening areas that are weak or lack an adequate level of thought or planning.

40. Assign the client to share his/her relapse prevention plan with those who are going to be supportive so they might help with implementation, support, and feedback of the plan.

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DIAGNOSTIC SUGGESTIONS

Axis I:	307.89	Pain Disorder Associated With Both Psychological Factors and an Axis III Disorder
	307.80	Pain Disorder Associated With Psychological Factors
	300.81	Somatization Disorder
	300.11	Conversion Disorder
	296.3	Major Depressive Disorder, Recurrent

300.3	Obsessive-Compulsive Disorder
302.70	Sexual Dysfunction NOS
304.10	Sedative, Hypnotic, or Anxiolytic Dependence
304.80	Polysubstance Dependence
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